Medical professionalism in the modern era

by Richard L. Byyny, MD, FACP

The modern era of medicine has brought about incredible advances in science and technology designed to improve the care of patients and population health. At the same time, major social changes are occurring that impact society, patients, physicians, medicine, health care, and medical education.

Medical professionals are governed by ethical codes, and profess a commitment to competence, integrity, morality, altruism, and support of the public good. This is a social contract, a covenant of trust with patients and society that determines medicine's values and responsibilities in the care of the patient.

Medical professionalism continues to be a core value and responsibility of physicians in the care of patients. Sir William Osler made the point, "the good physician treats the disease; the great physician treats the patient who has the disease."[1] As physicians and medical professionals committed to caring for patients, meeting professionalism responsibilities requires that we identify, understand, develop, and implement best practices in the education and development of future generations of physicians, and medical professionals.

As an important part of our commitment to medical professionalism, we must address the role of changes in society, our profession, scientific medicine, students, residents, colleagues, the business of medicine, government, and other aspects of the modern era.

The changes presented by this modern era require leadership and education on the critical core values and ethics in medicine, and the care of the patient.

Professionalism past, present, and future

The first oath for medical ethics was written as The Code of Hammurabi in 2000 BC. Hippocrates and Maimonides subsequently developed oaths codifying the practice of medicine as the sacred trust of the physician to protect and care for the patient, and a set of values for physicians.[2,3] Both emphasized teaching and learning, and the primacy of benefiting the sick according to one's ability and judgment while adhering to high principles and ideals. These oaths were a form of social contract that codified what patients and society should expect from the physician.

Hippocrates combined physicians' scientific and ethical promises with the precept against intentional harm as a central ethical duty, and humility as a core virtue.

In the 1800s, Thomas Percival developed the concept of shared professional responsibilities with the Manchester infirmary rules.[4] He recognized the complexity of the medical environment in hospitals, coined the terms "medical ethics" and "professional ethics," and developed the profession's compact with society.

The 1847 Code of Medical Ethics of the American Medical Association was a landmark in medical professionalism.[5] Derived from Percival's earlier work, it was the first national code of ethics for any profession. It was an explicit professional compact defining obligations to patients, colleagues, and community, along with reciprocity. It implied social and economic rewards for those in the profession in exchange for putting patients' interests first, and required competence of practitioners and guarding of the public's health.

AΩA was founded in 1902, before the Flexner report and the Liaison Committee on Medical Education. Medical student William Root and a group of his fellow students were shocked by the lack of interest in high academic achievement by their faculty and other students in medical school. They found the behavior of students and faculty to be boorish, and clearly lacking in professional values. In establishing AΩA, they wrote: "The mission of AΩA is to encourage high ideals of thought and action in schools of medicine, and to promote that which is the highest in professional practice."

They established the AΩA motto as "Be worthy to serve the suffering," and developed the mission of AΩA:

Dedicated to the belief that in the profession of medicine we will improve care for all by:
- Recognizing high educational achievement;
- Honoring gifted teaching;
- Encouraging the development of leaders in academia and the community;
- Supporting the ideals of humanism; and
- Promoting service to others.

They defined the duties of AΩA members:

To foster the scientific and philosophical features of the medical profession and of the public, to cultivate social mindedness as well as an individualistic attitude toward responsibilities, to show respect for colleagues and especially for elders and teachers, to foster research, and in all ways to strive to ennoble the profession of medicine and advance it in public opinion. It is equally a duty to avoid that which is unworthy, including the commercial spirit and all practices injurious to the welfare of patients, the public or the profession.

In 1912, U.S. Supreme Court Justice Louis Brandeis wrote:

A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge, and to some extent learning, as distinguished from their skill; a profession is an occupation which is pursued largely for others and not merely for oneself; it is an occupation in which the amount of financial return is not the accepted measure of success.[6]

In 2004, Drs. Richard and Sylvia Cruess wrote that the profession of medicine is:

An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it, is used in service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice, and the privilege of self-regulation. Professions and their members are accountable to those served, and to society.[7]

Today, the profound and rapid advances in medical knowledge, technology, specialized skills, and expertise are changing faster than medical schools and practitioners can keep up. These rapid changes, along with the fact that many physicians are now employees in the corporatization of medicine, have created different values.

These changes make it even more important that we practice medicine based on core professional beliefs and values in the doctor-patient relationship and the care of the patient. Physicians must understand their obligations and commitments. They must put patients first and subordinate their own interests to those of others. They must adhere to the highest ethical and moral standards.

Medical professionalism continues to be one of our profession's most important commitments, and signifies our trustworthiness, accountability, and commitment to patients.

Medical professionalism must also be recognized as an active, ongoing, and iterative process that involves debate, advocacy, leadership, education, study, enforcement, and continuous transformation. There should be no capitulation to efforts or circumstances that undermine ethics, values, or medical professionalism.

Transformation

There has been dramatic transformation in medicine over the last several decades, from the private independent practitioner to the organization of a common group of physicians, to a corporate group of physicians, often employed by hospitals and systems. Medicine has also seen the introduction of entrepreneurs, investors, and corporate executives. No matter where or how they are employed, physicians are obligated to adhere to an ethical ideal and professional values that focus on providing care in the best interest of patients.

In the modern era, professionalism is threatened by issues of self-interest, power, prestige, profit, pride, privilege, and lifestyle. Venality, character deficiencies, irresponsibility, and greed can be underlying factors for unprofessional behavior.

The commodification of health care as a product, like any other left to the ethos of the marketplace, competition, commercialization, and profit-making, is a current day social factor influencing the profession and professionalism. Commodification results from the legitimization of profit, competition, and self-interest inherent in a free-market economy wherein medicine is just another product or commodity, and not a social good and human benefit. The physician is now conflicted between the values and needs of patients and the medical organization that is the employer.

Medical organizations now strive for increased profits and efficiencies by curbing costs. This results in the conflict of medical professionalism versus the lack of medical ethics and values in business. Physicians, as healers and professionals, are often not evaluated or respected for their competent and professional care of patients. A physician's professional worth is now measured in productivity—how many patients can be scheduled and quickly seen.

Medical professionalism and its tenets are challenged, and its content considered negotiable or a changeable construct of societal mores. This was foreseen by Paul Starr in 1982 in "The Transformation of American Medicine."[8] He predicted the growing privatization and monetization of medicine.

The generation gap

There are evolving generational differences in students, residents, faculty, and practitioners. Each generation has its own set of characteristics, defining moments, and values, with shared conflicts and achievements. There are traditionalists or the Silent Generation, Baby Boomers, Generation Xers, and now the Millennials. Ethical values differ among these generations, as well as differences in lifestyles, work styles, and leisure activity.

More than 10 years ago, when I was Chancellor of the University of Colorado at Boulder, I had the privilege of teaching undergraduate students in the President's Leadership Class. There were some pre-medical students, along with those majoring in engineering, business, science, and humanities and arts. Using case-based teaching, I presented on a 56-year-old president of a successful company in diverse businesses including technology. He was married and had three pre-collegiate children. He was wealthy, and prominent in the community. The company had increasing profitability until the last few years when they leveled off and began to slow. He was under increasing pressure to turn the company around. He had a vacant executive position. It was such an important position that after his staff had screened and interviewed all the candidates, he decided to personally interview the finalists.

One candidate was a highly successful mid-career male executive. The CEO began the interview with the usual preliminary questions. He then asked how the candidate could contribute to the company. The candidate smiled while answering, "I know you have been struggling recently, and you know I work for one of your competitors." He opened his briefcase and pulled out some DVDs and said, "All of my current employer's database and information is on these DVDs. If I get the job, they are yours."

The students were asked, "If you were the CEO what would you do?"

It was a shock when more than 60 percent of the students said they would hire the candidate and take the DVDs. They rationalized that it would help the company through a difficult time in a competitive business. Some said the CEO needed to maintain his job, income, and stature in the community. Some worried about his wife, and if he lost his job how the children would fare and be able to attend an expensive exclusive college. They worried that he may have to move out of his huge home in a gated community.

When the students who would not hire the man were asked why, half said what he was doing was illegal, while the other half felt it was unethical and the wrong thing to do.

This is a generation that has grown up with computers and social media. They view the world in a different context than previous generations. Today's medical students have never used a rotary phone or pay phone. They have never had to get up off the couch to change the channel on a TV that only gets three or five channels. They've never held a transistor radio to their ear. Their textbooks

are provided to them in electronic format. The world is at their fingertips through the Internet. For many, the presentation of information has become an insidious influence in losing intellectual independence.[9]

In today's world, anyone with a computer, tablet, cell phone, or other electronic device is bombarded with jibber-jabber, rumor, and opinions from people who presume to know, remember, or have biases with inaccurate or false information.

When information is presented, listening with a discerning ear is required. Confirmation of the information presented through trusted, reliable sources is vital. Technology, information, and data as presented and accessed may be an impediment to knowledge, learning, and core values.

Is medicine nothing special? Is it just an occupation like any other? Is the marketplace the appropriate venue for health care? Is the assumption that patients will fare better if competition is unfettered and profit is encouraged and acceptable? We are often facing a critical dilemma with ethical and moral capitulation, and unprofessional accommodations.

Defining best practices—Reflections from the AΩA Professionalsim Conference

In 2016, AΩA held its third Professionalism Think Tank Conference "Medical Professionalism Best Practices: Professionalism in the Modern Era." Many times during the conference there were new or different insights that influenced the group's learning and understanding of medical professionalism in the modern era. The discussions were thoughtful, insightful, inspiring, and educational. The sharing of information was designed to instill creativity and develop best practices to learn how to better care for patients, and each other, in the modern era.

There was a consensus among the group that medicine in the 21st century will need to be based on the moral foundations of professionalization and professionalism in the care of the sick, and will require trust in a physician's competence.

The responsibility of medical educators is to teach the next generation, and ensure that the primacy of the welfare of patients is foremost and will be preserved based on moral status and integrity. Medicine must continue as a moral and responsible profession.

In 2002, the ABIM Foundation, in conjunction with the American College of Physicians Foundation, and the European Federation of Internal Medicine, authored *Medical Professionalism in the New Millennium: A Physician Charter.* The fundamental principles of the Charter are the primacy of patient welfare, patient autonomy and social justice. The Charter also articulates the professional commitments of physicians and health care professionals in the modern era.[10]

Many professional organizations have also developed a set of professional responsibilities around:

- Professional competence;
- Honesty with patients;
- Patient confidentiality;
- Maintaining appropriate relations with patients;
- Improving quality of care;
- Improving access to care;
- Just distribution of finite resources;
- Scientific knowledge;
- Maintaining trust by managing conflicts of interest; and
- Professional responsibility.

Although most schools have curricula related to professional values, what students learn and retain can often be from what is called the "hidden curriculum"—the day-to-day experiences of students working in the clinical environment while watching, listening, and emulating resident and physician behaviors. Fortunately, many schools and teaching hospitals have implemented curricula to improve medical professionalism, and some have attempted to develop methods of evaluating aspects of professionalism. The most effective programs lead by changing the entire culture and environment to respect and reward professional behavior, and to diminish the negative impact of the hidden curriculum.

However, we shouldn't presume that professional core values in medicine are intuitively apparent. There is ongoing debate about the importance and value of a physician's oath or solemn promise. We must have clear professional expectations that are explicit for all physicians, and a commitment for physicians to respect and uphold a code of professional values and behaviors. These include the commitment to:

- Adhere to high ethical and moral standards—do right, avoid wrong, and do no harm.
- Subordinate personal interests to those of the patient.
- Avoid business, financial, and organizational conflicts of interest.
- Honor the social contract with patients and communities.
- Understand the non-biologic determinants of poor health, and the economic, psychological, social, and

cultural factors that contribute to health and illness—the social determinants of health.

• Care for all patients regardless of their ability to pay, and advocate for the medically underserved.

• Be accountable, both ethically and financially.

• Be thoughtful, compassionate, and collegial.

• Continue to learn, and strive for excellence.

• Work to advance the field of medicine, and share knowledge for the benefit of others.

• Reflect dispassionately on one's actions, behaviors, and decisions to improve knowledge, skills, judgment, decision-making, accountability, and professionalism.

Efforts in medical professionalism continue to be a work in progress. As physicians, we are continually learning about medical professionalism, and how to maintain and improve a standard of physician behavior. We need to remember that we call our work "the practice of medicine" because we are always practicing our profession to learn and improve. Our goal is not perfection, but continuous learning, improvement, and focusing on what is best for the patient.

Constructs of professionalism

Professionalism, as a construct, has changed dramatically over the past 40 years. Initially, professionalism was associated with personal character, virtues, ethics, and humanism. Later, professionalism became a competency with behaviors to be demonstrated and assessed.

More recently, professionalism has come to be viewed as a matter of professional identity formation.

Three models of professionalism

The centuries old model of professionalism is associated with virtues and ethics. A good physician is a person of character who is able to apply ethical principles, curb self-interest, demonstrate the virtues of compassion and respect, and be humanistic, trustworthy, and caring.

In the 1990s, a different model arose around behaviors and competencies. The behavioral model emerged in response to the perceived failure of the virtues model to translate ethical instruction into ethical action. The good physician, according to behaviorists at the time, was a person who manifested a defined set of behaviors, and demonstrated professionalism competencies.

In the past decade, a third model appeared: professional identity formation. This approach developed in reaction to concerns about the reductionist, behavioral model, and described the progressive incorporation of the values and aspirations of the profession into the identity of the person as a physician. The good physician takes on the identity of a community of practice, and is socialized into the values, aspirations, and behaviors of the field.

Each model has strengths and limitations, and each adds to the greater whole. Professionalism can be viewed as a matter of character, humanism, and ethical reasoning, which is inspiring to learners and practitioners.

Professionalism can also be seen as adoption of appropriate behaviors, and demonstration of an area of competence, which tightly aligns instruction and assessment. Professionalism can be viewed as a process of being and becoming—of taking on the identity of a medical professional, a healer, and a physician, which is also inspiring, and encourages self-reflection.

Best Practices:

– Professionalism describes the process by which students, residents, faculty, and leadership psychologically develop through social processes of instruction, coaching, feedback, reflection, and identity formation.

– Professionalism lapses should be dealt with differently depending on whether it is considered to be an inability to apply ethical principles, an instance of inappropriate behavior, or a lack of insight into one's own professional identity.

– At the level of individual learner and practitioner, opportunities exist to move from talking about ideals and aspirations of professionalism to helping students and faculty negotiate value conflicts, and balance tensions in moments of stress.

– With the changing demographics of today's learners, the values of professionalism must be made explicit and taught directly. Students must be taught how to negotiate situations where unprofessional actions are being observed.

– Schools and hospitals need to teach professional standards and practices, ensuring that learners understand why the standards exist, and explaining the consequences of not meeting the standards.

– Patients are harmed by failure to disclose errors and mistakes. The ability to report and apologize requires peer support, coaching on disclosing errors to patients, and a complementary system that values transparency and humility.

Professional identity formation

The emphasis on professional identity formation resulted from the recognition by medical educators that an

individual's identity begins to emerge at birth and proceeds in stages throughout life with the period beginning in the late teens, and stretching into early adulthood being particularly important. The process of professional education in medicine is superimposed on this normal development, and has a profound impact on the identities that emerge.

Individuals, at a particularly formative stage of their lives, enter medical school with preexisting identities that have been shaped by both nature and nurture. During the long period of undergraduate and postgraduate education, each learner must come to terms with these norms of the community of practice that they are entering. These norms are actually outlined in the definitions of profession and professionalism, as well as a list of characteristics or attributes. Each learner must care for patients with these norms.

The major factors impacting identity formation in medicine are role models and mentors, and both clinical and nonclinical experiences.

One way to achieve this essential objective is to specifically design educational programs that support individuals as they develop the professional identity necessary for the practice of medicine, so that each practitioner has come to think, act, and feel like a physician.

Best Practices:

– Professional identity formation—the development of professional values, actions, and aspirations—is the backbone of medical education.

– Medical students acquire the identity of a physician during the course of their educational experiences. They aspire to join in a community of practice—the practice of medicine—with a shared competence and professionalism they acquire from role models, mentors, and experiences. Physician identity is that of a healer, and a medical professional.

– The ultimate objective of medical education is to ensure that individuals are professional in their behavior because of who they have become. To achieve this, medical schools must design specific education programs that support individuals as they develop the professional identity necessary for the practice of medicine—to think, act, and feel like a physician.

– The central issue with learning is becoming a practitioner, not learning about practice.

Generational differences

Whether the situation involves work hours, social media, or digital devices, a shared understanding of professional comportment is essential. Generational differences can lead to different interpretations of professionalism, and communication is the key to avoiding misunderstanding.

Professionalism disconnects can arise from different personal and generational viewpoints. Professionalism can be contextual and situationally nuanced. Establishing safe spaces for direct communication, and educating faculty and learners about the ways to communicate and navigate professionalism differences will help reduce the generational angst, allowing us to work together as professionals, in healthy environments, and on collegial teams.

Best Practices:

– Generational differences can lead to different interpretations of professionalism. Communication is the key to avoiding misunderstanding.

– Define appropriate and inappropriate behaviors. Review expectations, encourage and respond to questions, and establish a shared understanding of rules and consequences.

– Model professional behavior. Be aware of inadvertent lapses in professionalism, and acknowledge them when they occur.

– Communicate directly. Timely communication in an appropriate environment is key. Articulate concerns in an objective manner, seek to understand other's perspective, and clearly state expectations.

Caring

Medical professionalism should be seen as a tiered construct divided into basic professionalism (doing the right thing well), and higher professionalism (service that transcends self-interest). Both require a physician who cares.

In 1902, Osler told members of a medical society, "The times have changed, conditions of practice have altered and are altering rapidly, but…we find that the ideals which inspired [our predecessors] are ours today—ideals which are ever old, yet always fresh and new, and we can truly say in Kipling's words:

And the men bulk big on the old trail, our own trail, the out trail,
And life runs large on the Long Trail—the trail that is always new."

The trail for the men and women of the new millennium presents steep climbs, especially if they are to be more than technicians who care. However, if they can

achieve a level of caring in which service transcends self-interests; if they can care not just for individual patients but also for the greater good; if they can care about caring as a subject deserving their continued attention, then their capacity for good knows no limits.

Best Practices:

– A physician professional is a competent clinician and is "working to serve the suffering."

– By achieving a level of caring in which service transcends self-interest, physicians can care for individual patients, and also for the greater good.

– When caring is a subject deserving of continual attention, then an individual's capacity for good knows no limits.

Retraining professionals

Is professionalism all about following the rules? If so, whose rules? Were these rules generated by the profession? The organization? Some hard-to-untangle mash-up of the two? How do formal framings, the bureaucratic scaffold of the educational enterprise, and the financial undercurrents of delivering health care, cause medical schools to function as little more than farms in the production of a certain sheep-like product?

Are we, as faculty, internalizing a sheep farming approach to professional preparation? How do the forces of unconscious bias, group preservation, and the desire to select and train future generations of physicians to be just like us push a follow-the-rules, role-model-reverence, and etiquette-based approach to professionalism?

What might happen if we deliberately reimagine medical schools not as sites of cultural reproduction (a.k.a. factories), but rather as sites of cultural resistance? Resistance could be operationalized as skill sets designed to:

1. Problematize the application of routine solutions to non-routine problems; and
2. Recognize where and how market incentives and bureaucratic structures leak streams of tacit messages into the learning environment contrary to core professionalism principles.

There is considerable conflict between what students aspire to, and what they are being educated/programmed/socialized to do. The overall picture is one of medical schools as sites of cultural reproduction rather than sites of cultural resistance.

Medical education and medical educators must step back and ask themselves the teleological question, "to what end?" What is the function of medical education? What are the challenges to which we seek to train professionals for the modern era? What are the practice environments of the future, and how should our future practitioners—as professionals—fit (and not fit)?

We need to subject educational practices to a more extensive array of theatrical, conceptual, and occupational lenses. It is not altogether clear whether the norms that currently guide medicine's professionalism movement remain its own, and are sufficiently distinct from a rules-based/command and control/professionalism-police framing of what it means to be a good doctor. There is concern about how medicine's professionalism movement is sufficiently generated internally, and renewed, as opposed to being set by external interests. If the agenda is internally set, medicine might be perverting its own core principles by promulgating a just-follow-the-rules framing of professionalism, thus becoming a version of the famous Pogo dictum, "We have met the enemy and he is us."

Medical educators must think long and hard about the structural and cultural context of their training environments. This means moving beyond a preoccupation with content. Learning is never context free. There is no such thing as an informationally indifferent, or message-balanced learning environment. There are no revenue neutral, or neutral-to-revenue, learning environments.

Learning environments are awash with messaging, much of which functions to shape the identity of physicians as professionals. The impact of industry and markets on the learning environments of medical trainees is both real and appreciable. So too are the bureaucratic messages of order and social control. All exert pressures on how work is carried out and valued, including the technical aspects of that work.

If being a good doctor is learned within a dynamic interplay of professional, bureaucratic, and market messaging, where do we encounter a framing of professionalism as something other than top-down, sheep-like messaging (rules)? Or, as normative aspirational chants that ask practitioners to rise above, or temporarily hold in abeyance, any such anti-professional pressures? Where do we find within the formal curriculum a view of professionalism where bureaucracy and markets are identified as countervailing forces that require resisting for the sake of medicine's soul?

Bureaucratic and market forces will continue to battle for the hearts and minds of 21st century professionals essentially unopposed by the ethos, ethics, and practice of

professionalism. In the end, none of this is about saving the world for professionals, rather it is about saving health care for patients and the public in a world where mission increasingly is defined in terms of margins, and where standardization will deliver inappropriate care to both ends of any illness distribution.

Best Practices:

– Apply an extensive array of theatrical, conceptual, and occupational lenses to educational practices.

– Move beyond content—learning environments are inundated with messaging to shape the identity of physicians as professionals.

– Resist stasis by constructing learning environments that will cultivate curiosity and attentiveness, and result in physicians doing the right thing for patients, families, and our profession.

Building an infrastructure to support professionalism

Medical educators and leaders of health systems have enormous opportunities to shape the professional development of learners. The determining factor is whether they try to do so with a balanced approach.

To support and sustain learners' development, it is crucial to identify and build sustainable models to ensure that learners are exposed to positive role models, and introduced to how professionals self-regulate, and why. Curricula and experiential learning approaches are unlikely to have a lasting impact if organizations fail to put in place the right people, processes, and technology to address unprofessional behaviors among senior team members, as well as learners. Unless there is a balanced approach, professionalism education will not have a sustained and lasting impact on learners and delivery of care that is safe, effective, and patient-centered. Organizations need to have the right people, processes, and technology in place to appropriately address "disturbances in the force" in a timely manner, and reduce the probability of pattern development in role models, and ultimately, in learners.

As demonstrated at Vanderbilt University Medical Center, supporting educational development and professional identity formation of learners through careful attention to life-long learning principles, self-directed learning, and reflection are important foundations of professionalism education. However, without an organized approach to support professional accountability with the right people, processes, and technology to address negative role models and sustain the effort, we are likely to see an unending cycle of unprofessional behaviors, moral distress, and cynicism.

Drexel University College of Medicine has developed a comprehensive, longitudinal professionalism curriculum with elements across courses and clerkships in multiple institutions and teaching hospitals that promote understanding of professionalism and professional formation of trainees. The curriculum includes clinical ethics; humanism; personal awareness and reflective practice; empathic communication skills and compassion responsiveness; commitment and accountability to the professional community; and cultivation of physician virtues.

Appreciative debriefing and inquiry promote a positive culture of social support among students. A multifaceted assessment system identifies at-risk students who may benefit from additional faculty support or remediation strategies.

Best Practices:

– Medical educators and leaders of health systems can, and should, shape the professional development of learners through a balanced approach, supporting educational development and professional identity formation using life-long learning principles, self-directed learning, and reflection.

– Health care systems must have an organized approach to support professional accountability with the right people, processes, and technology.

– A comprehensive, longitudinal professionalism curriculum with elements across courses and clerkships that promote understanding of professionalism and professional identity formation, is needed.

– Clinical ethics, humanism, personal awareness, reflective practice, empathic communication skills, compassionate responsiveness, commitment to accountability, and cultivation of physician virtues are core to the medical school curriculum.

The learning environment

U.S. Census data shows that the profile of young Americans age 18–34 years has changed dramatically. The proportion of young adults who are racial and ethnic minorities has doubled in the last 30 years; one in four of this cohort speak a language other than English at home; and far fewer of this group were born in the U.S. compared to their peer group in 1980. This change in the profile of medical school matriculants corresponds with, and may even be due to, an evolution in the way in which individual medical schools are assessing and evaluating applicants.

In response, the Association of Academic Medical Centers began working with individual medical schools to implement a holistic review of medical education to incorporate key aspects of behavior, character, and performance that have direct impact on the practice of medicine, and which are not easily assessed by academic performance or standardized test scores.[5] Through national presentations, on-site training at medical schools, and broad dissemination of resources, the practice of holistic review in medical school admissions has become widespread over the last 10 years. Holistic review allows medical schools to consider the qualities of an outstanding physician, and look for experiences and attributes in the applicant that may presage the future attainment of such traits.

The circumstances that characterize the learning environment are resulting in multiple new challenges. Overburdened faculty are now addressing concerns such as duty hour limits; managing an ever-increasing set of responsibilities related to paperwork; demands for increasing productivity in a challenging fiscal environment; increased regulation by oversight agencies; and a larger number of student learners, all of which combine to reduce time for teaching. Add to this, advances in pedagogic technology including the use of simulation and standardized patients, as a replacement for direct patient contact due to safety concerns.

Medical educators must now navigate a new generation of learners, and a learning environment contending with multiple new challenges and strict guidelines focused on teaching and evaluating professionalism. By exploring specific scenarios related to professionalism challenges, either from an individual learner's perspective or in the learning environment, we can assess the different options that might be utilized to address these incidents and what the potential results might be.

Taking lessons from the student's perspective, the Pritzker School of Medicine has worked hard to enhance collaborative learning across all components of the curriculum by expanding the content of the health care disparities course to include training in intersectional practice and patient care for the LGBTQI community; implementing implicit bias training; and increasing the number of underrepresented students. To address the lack of diversity among the faculty, the dean of the biological sciences division appointed a new associate dean whose role is to launch an institutionwide initiative to enhance diversity and inclusion at all levels, from faculty to residents and fellows, to graduate and medical students, to staff.

The school has enhanced the level of support for all students, by launching a new Wellness Committee which provides programming for the entire school. The school also convened an Identity and Inclusion Steering Committee composed of faculty, students, and staff who are charged with providing ongoing direction for programs and/or curricula that support an inclusive learning environment, and promote respectful and effective communication with diverse patients and colleagues around issues of identity.

We must preserve the core values of medicine, and act directly on behalf of the patients and families whose care will be entrusted to the next generation of physicians.

Best Practices:

– Enhance collaborative learning across all components of the curriculum to include training in intersectional practice and patient care for vulnerable and underserved populations.

– Implement implicit bias training for students, faculty, and leadership.

– Medical educators must consider the appropriate response to support the highest standards of professional behavior in students, and the characteristics of a learning environment that supports these standards.

Inclusiveness

Inclusion is a core competence for professionalism in the 21st century.

Developing interprofessional teams of providers to care for increasingly diverse populations, and conducting interdisciplinary research in a competitive global environment are essential to achieving high quality, culturally-mindful care with enhanced innovation.

Given the growing diversity of the U.S. population, the delivery of culturally appropriate care is critically important. When the socioeconomic environment influences the health of patients and the effectiveness of treatment, the ability to care for patients is negatively impacted.

Medical professionalism and the social and economic landscape of society are inexorably intertwined. If the healing arts intend to fulfill the goal of addressing the health of patients and the communities in which patients reside, then the ills that impact vulnerable communities must be taken into consideration, including the rising cost of health care. Unless these issues are addressed, i.e., social justice, efforts to enhance the quality of care will not be successful.

There is an increased recognition of implicit bias and its impact on professionalism and personal lives. In medicine, these biases can impact medical school admissions,

delivery of care, and federal policy. Evidence-based tools are available to assist individuals and institutions in interventions to mitigate bias.

To build a more inclusive culture it is important to recognize our own biases and develop strategies to mitigate them.

The interventions suggested for health care systems include:

- Promote the consistency and equity of care using evidence-based guidelines.
- Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities.
- Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
- Support the use of interpretation services where community need exists.
- Support the use of community health workers.

As medical professionals, it is important to consider these recommendations, support them institutionally, and recognize our biases in every patient interaction.

Medical professionalism cannot be viewed in isolation given the significant contributions of the socioeconomic factors to the health and well-being of patients. As providers, it is our responsibility to acknowledge these external factors, and to openly discuss the challenges that may be impacting patients. We also have a responsibility to each other, being mindful of our own biases and how they may impact our professional interactions.

The development of interprofessional teams, and conducting interdisciplinary research are essential to achieving high quality, culturally-mindful care with enriched innovation.

Best Practices:

– Acknowledge the socioeconomic factors and social determinants of health, and openly discuss the challenges that may be impacting patients and the delivery of care.

– It is the responsibility of educators, residents, faculty, and leadership to develop strategies for use in personally uncomfortable situations.

– Be mindful of biases and how they impact professional interactions and patient care.

Conclusion

Professionalism has been a core tenet of the AΩA

mission for more than 115 years. Now, more than ever, we must take a leading role in ensuring that professionalism is the foundation of our covenant with society.

AΩA will continue its commitment to medical professionalism, and it is our hope that all medical educators will work with us to promote best practices in medical professionalism in the modern era.

Therefore, *The Pharos* will continue to seek and publish papers on professionalism in medicine. To submit a paper to *The Pharos* for consideration by the Editorial Board for publication, visit http://alphaomegaalpha.org/contributors.html.

To obtain a copy of the first AΩA monograph *Medical Professionalism Best Practices*, and/or the second AΩA monograph *Medical Professionalism Best Practices: Professionalism in the Modern Era*, please send an e-mail with your mailing address, and the number of copies of each publication you would like to receive, to info@alphaomegaalpha.org.

You may also view the AΩA monographs online at alphaomegaalpha.org.

"Be worthy to serve the suffering."

References

1. Bliss M. William Osler: A Life in Medicine. Oxford (UK): Oxford University Press; 1999.

2. Edelstein L. The Hippocratic Oath: Text, Translation and Interpretation. Baltimore (MD): Johns Hopkins University Press; 1043.

3. Tan SY, Yeow ME. Moses Maimonides (1135-1204): Rabbi, philosopher, physician. Singapore Med J. 2002; 43: 551−3.

4. Manchester Infirmary Rules. University of Manchester Special Collections; 1922. https://archiveshub.jisc.ac.uk/data/gb133-mmc3-16/mmc/9/6/1/14.

5. Editorial. Thomas Percival (1740−1804) Codifier Of Medical Ethics. JAMA. 1965; 194(12): 1319−20.

6. Justice Louis Brandeis. A Profession. Address at Brown University Commencement; 1912.

7. Cruess SR, Cruess RL. Professionalism and Medicine's Social Contract with Society. Virtual Mentor. April 2004; 6(4).

8. Starr P. The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry. New York: Basic Books; 1982.

9. Byyny RL. Information and Cognitive Overload. Pharos Alpha Omega Alpha Honor Med Soc. Autumn 2016; 79: 2−7.

10. ABIM Foundation. The Physician Charter. http://abimfoundation.org/what-we-do/physician-charter.